AMENDED IN SENATE JULY 6, 1998

AMENDED IN ASSEMBLY MAY 22, 1998

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AMENDED IN ASSEMBLY FEBRUARY 24, 1998

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

ASSEMBLY BILL No. 1667

Introduced by Assembly Members Migden, Baugh, and Richter

January 14, 1998

~~An act to amend Section 1368 of, and to add Article 12 (commencing with Section 1399.80) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 2.7 (commencing with Section 10309) to Chapter 4 of Part 2 of Division 2 of the Insurance Code, relating to health.~~ *An act to amend Sections 1368, 1368.01, 1368.03, and 1368.04 of, and to add Article 12 (commencing with Section 1399.80) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 2.55 (commencing with Section 10145.80) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health insurance.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1667, as amended, Migden. Health care service plans: disability insurers: appeals.

(1) Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations.

Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review.

This bill would require health care service plans to provide subscribers and enrollees with written responses to grievances, as specified, and would provide that a grievance may be submitted to the department by an enrollee or subscriber after participating in the plan's grievance process for 45 days. The bill would require the department to respond to each grievance in writing within 45 days.

(2) Existing law requires every health care service plan and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for individual enrollees or insureds who have a terminal condition and meet certain specified criteria.

This bill would, on and after January 1, 2000, require the Commissioner of Corporations and the Insurance Commissioner to contract with one or more independent review organizations to conduct independent medical reviews, as specified. The bill would require the Commissioner of Corporations and the Insurance Commissioner to contract, by July 1, 1999, with a private, nonprofit accrediting organization to accredit the independent medical review entities that are to conduct these independent reviews. The bill would enact other related provisions.

(3) Under existing law, a willful violation of the provisions governing health care service plans is a crime.

By changing the definition of the crime applicable to these plans, this bill would impose a state-mandated local program.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs

mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

(5) This bill would also provide that it shall not become operative unless SB 1504 and SB 1653 are also enacted and become operative.

~~Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations. Existing law requires health care service plans to provide an external, independent review process to examine the plan's decisions regarding experimental or investigational therapies for certain enrollees.~~

~~This bill would establish in the department the Independent Health Care Appeals Program for Health Care Service Plans to provide an independent medical necessity or appropriateness of services review of final decisions of a health care service plan to deny, reduce, or terminate benefits in the event the final decision is contested by an enrollee. The bill would authorize the department to charge to the enrollee a processing fee to apply for review under the program. The bill would require the Commissioner of Corporations to, among other things, contract with one or more independent utilization review organizations in the state to conduct the appeal reviews and make a recommendation. The bill would require the plan to implement the recommendation. The bill would require the plan to bear the cost of the appeal review pursuant to a schedule of fees established by the department.~~

~~Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review. Under existing law, the plan's grievance system is required to include a system for complaints that are pending and unresolved for 30 days or more.~~

~~This bill would authorize an enrollee or subscriber to submit the grievance or complaint to the Independent Health Care Appeals Program for Health Care Service Plans proposed by this bill, rather than the department. The bill would also require that the enrollee participate in the plan's grievance process for at least 30 days, rather than for at least 60 days, or for 72 hours, under specified circumstances.~~

~~Existing law provides for the regulation of policies of disability insurance administered by the Insurance Commissioner.~~

~~This bill would establish in the Department of Insurance the Independent Health Care Appeals Program for Disability Insurers to provide an independent medical necessity or appropriateness of services review of final decisions of disability insurers to deny, reduce, or terminate benefits in the event the final decision is contested by a policyholder identical to that described above for health care service plans, but under the direction of the Insurance Commissioner.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1368 of the Health and Safety~~

SECTION 1. This act shall be known as the Patient's Independent Medical Review Act of 1998.

SEC. 2. Section 1368 of the Health and Safety Code is amended to read:

1368. (a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The

information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for ~~complaints~~ *grievances* to be given to subscribers and enrollees who wish to register written ~~complaints~~ *grievances*. The forms used by plans licensed pursuant to Section 1353 shall be approved by the commissioner in advance as to format.

(4) *Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the denial, significant delay, termination, or other limits on health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity or medical appropriateness.*

(5) Keep in its files all copies of ~~complaints~~ *grievances*, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least ~~60~~ *45* days, a subscriber or enrollee may submit the grievance ~~or complaint~~ to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or participate in the process for at least ~~60~~ *45* days.

(B) A grievance ~~or complaint~~ may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance ~~or complaint~~ to the State Department of Health Services, the Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance ~~or complaint~~ to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance ~~or complaint~~ to the department. In addition, following submission of the grievance ~~or complaint~~ to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a ‘‘relative’’ includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) Every health care service plan regulated by the department shall prominently display in every plan contract, on enrollee and subscriber evidence of coverage forms, on the complaint forms required under paragraph (3) of subdivision (a), and on all written responses to grievances ~~and complaints~~, a notice of the right to submit unresolved grievances ~~and complaints~~ to the department for review.

(4) The department shall review the written documents submitted with the subscriber’s or the enrollee’s request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance ~~or complaint~~, or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. The department shall send a written notice of the final disposition of the grievance ~~or complaint~~, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within ~~60~~ *45* calendar days of receipt of the request for review unless the commissioner, in his or her discretion, determines that additional time

is reasonably necessary to fully and fairly evaluate the relevant grievance ~~or complaint~~. ~~— Distribution~~. *In any decision not subject to the independent medical review system established pursuant to Article 12 (commencing with Section 1399.80), the department's written notice shall include, at a minimum, the following:*

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the commissioner.

(B) A discussion of the department's contact with any independent qualified medical provider, or any other independent expert relied on by the department, along with a summary of the views of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or part, information about the corrective action taken and any penalties imposed by the department.

Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(5) On or before January 1, ~~1997~~ *1999*, the commissioner shall establish and maintain a system of aging of ~~complaints~~ *grievances* that are pending and unresolved for ~~60~~ *45* days or more, that shall include a brief explanation of the reasons each ~~complaint~~ *grievance* is pending and unresolved for ~~60~~ *45* days or more.

~~(5)~~

(6) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance ~~or complaint~~ to the department. The use of mediation services shall not preclude the right to submit a grievance ~~or complaint~~ to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the

agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of ~~complaints~~ *grievances* that are pending and unresolved for 30 days or more. On or before January 1, 1997, the plan shall provide a quarterly report to the commissioner of ~~complaints~~ *grievances* pending and unresolved for 30 or more days with separate categories of ~~complaints~~ *grievances* for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each ~~complaint~~ *grievance* is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the commissioner:

> ''Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, ~~complaints~~ *grievance* pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights.''

If requested by a plan, the commissioner shall include this statement in a written report made available to the public and prepared by the commissioner that describes or compares ~~complaints~~ *grievances* that are pending and unresolved with the plan for 30 days or more. Additionally, the commissioner shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why ~~complaints~~ *grievance* described in that written report are pending and unresolved for 30 days or more. The commissioner shall not be required to include a statement or append a brief explanation to a written report that the

commissioner is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance~~, complaint,~~ or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider ~~complaint or~~ grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

SEC. 3. Section 1368.01 of the Health and Safety Code is amended to read:

1368.01. (a) The grievance system shall require the plan to resolve grievances within 30 days whenever possible and shall require the plan to provide enrollees and subscribers with a written statement on the disposition or pending status of the grievance within 30 days of the plan's receipt of the grievance.

(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than ~~five~~ *three* days from receipt of the grievance.

SEC. 4. Section 1368.03 of the Health and Safety Code is amended to read:

1368.03. (a) The department may require enrollees and subscribers to participate in a plan's grievance process for up to ~~60~~ *45* days before pursuing a ~~complaint~~ *grievance* through the department. However, the department may not impose this waiting period in cases covered by subdivision (b) of Section 1368.01 or in any other case where the department determines that an earlier review is warranted.

(b) Notwithstanding subdivision (a), the department may refer any grievance ~~or complaint~~ to the State Department of Health Services, the Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

SEC. 5. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The commissioner shall, as appropriate, investigate and take enforcement action against plans regarding ~~complaints~~ *grievances* by enrollees and subscribers, *including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 12 (commencing with Section 1399.80)*. The commissioner shall periodically evaluate ~~complaints~~ *grievances* to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The commissioner may, after appropriate notice and opportunity for hearing, levy an administrative penalty, by order, in an amount not to exceed two hundred fifty thousand dollars ($250,000) if the commissioner determines that a health care service plan has knowingly committed, or has performed with ~~such~~ *that* frequency as to indicate a general business practice, any of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the commissioner to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the State Corporations Fund.

SEC. 6. Article 12 (commencing with Section 1399.80) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 12. Appeals Seeking Independent Medical Reviews

1399.80. (a) Commencing January 1, 2000, there is established in the department the Independent Medical Review System.

(b) (1) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by the plan if the plan's decision was based, in whole or in part, on a finding that the proposed health care services are not medically necessary or medically appropriate. For purposes of this section, "enrollee" shall include a designee as defined by paragraph (2) of subdivision (b) of Section 1368, and an enrollee's provider with the consent of the enrollee or the designee.

(2) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available. The enrollee's election to either pursue or not pursue, exhaust, or engage in the procedures described in this

article does not preclude the use of any other remedy provided by law and shall not be relevant in any subsequent civil or administrative proceeding.

(c) No later than January 1, 2000, every health care service plan regulated by the department shall prominently display in every plan contract, on enrollee and subscriber evidence of coverage forms, on the grievance forms required under Section 1368, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan, and on all written responses to grievances, information concerning the right of an enrollee, as provided in paragraphs (1) and (2) of subdivision (b), to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, significantly delayed, terminated, or otherwise limited by the plan, or by one of its contracting providers.

(d) An enrollee, including a medicare beneficiary enrolled in the health care service plan pursuant to the plan's contract with the federal Health Care Financing Administration, unless that application is expressly preempted by federal law, or a Medi-Cal beneficiary enrolled in a health care service plan under the plan's contract with the State Department of Health Care Services' Medi-Cal program, may apply to the department for an independent medical review when all of the following conditions are met:

(1) The enrollee's physician has recommended a treatment as medically necessary or medically appropriate, or the enrollee has received a treatment that the provider determined was medically necessary or medically appropriate for the enrollee's medical condition. For purposes of this article, the enrollee's physician may be an out-of-plan physician. However, the plan shall have no liability for payment of services provided by an out-of-plan physician except, as provided in subdivision (b) of Section 1399.84.

(2) The proposed or rendered treatment has been denied, significantly delayed, terminated, or otherwise limited by the plan, or by one of its contracting providers, based in whole or in part on the basis that the treatment is not medically necessary or is not medically appropriate.

(3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the denial is upheld. However, the enrollee shall not be required to participate in the plan's internal grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's internal grievance process for more than five business days.

(e) An enrollee may apply to the department for an independent medical review of the plan's decision within 60 days of any of the qualifying periods or events under subdivision (d), in a manner determined by the commissioner. The commissioner may extend the application deadline beyond 60 days if the circumstances of a case warrant the extension.

(f) The enrollee shall pay to the department an application processing fee of fifty dollars ($50), which shall be refunded if the enrollee prevails in the review. The commissioner may reduce or waive the fee in cases of financial hardship. The remaining costs of the review shall be borne by the plan as provided in Section 1399.84.

(g) As part of the application for an independent medical review, the enrollee shall provide the department with all of the following:

(1) A brief description of the enrollee's medical condition for which health care services were denied, significantly delayed, terminated, or otherwise limited.

(2) A copy of all information provided by the plan or any of its contractors concerning its decision regarding those health care services.

(3) Any materials the enrollee submitted to the plan in support of the grievance, and any additional material that the enrollee believes is relevant.

(4) A written consent to obtain any necessary medical records from the plan, any of its contractors, and any other out-of-network physician the enrollee may have consulted on the matter.

(h) Upon notice from the department that the health care service plan's enrollee has applied for an independent medical review, the plan shall provide to the department a copy of all of the following documents within five business days of the plan's receipt of department's notice of a request by an enrollee for an independent review:

(A) All medical records relevant to the enrollee's medical condition for which the treatment has been provided or recommended, provided the documents are in the plan's possession. Any medical records provided to the plan after the initial documents are provided to the department shall be forwarded by the plan to the department within five business days. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(B) A copy of any relevant documents used by the plan in determining whether the treatment should be provided, and any statement by the plan explaining the reasons for the plan's decision not to provide the treatment on the basis of medical necessity or medical appropriateness. The plan shall provide, upon request, a copy of documents required by this subparagraph, except for any legally privileged information, to the enrollee and the enrollee's physician. The department and the independent review entity shall maintain the confidentiality of any proprietary information of the plan.

(C) Any information that was submitted to the plan or to the plan's contracting provider by the enrollee or the enrollee's physician in support of the enrollee's request for the treatment. The confidentiality of any medical record information shall be maintained pursuant to applicable state and federal laws.

(i) Each independent medical reviewer shall base his or her determination on whether the proposed or rendered treatment is medically necessary or medically

appropriate on scientific and medical evidence regarding the efficacy of the proposed or rendered treatment, or on applicable, generally accepted practice guidelines. A reviewer's determination shall not consider the coverage terms and conditions of the health care service plan contract.

1399.81. (a) Upon receipt of an enrollee's request for an independent medical review, the commissioner shall assign the request to an independent medical review organization as described in Section 1399.82 when all of the following conditions are satisfied:

(1) The enrollee has provided an executed release to obtain necessary medical records.

(2) The enrollee has submitted payment for the application fee, unless the fee is reduced or waived.

(3) The commissioner finds that the plan's decision to deny, significantly delay, terminate, or otherwise limit treatment was based, in whole or in part, upon a determination that the proposed health care services are not medically necessary or medically appropriate.

(4) The enrollee has followed the plan's grievance process pursuant to subdivision (d) of Section 1399.80.

(b) The department shall immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved and, if not approved, the reasons therefor.

(c) If the request for review is approved, the department shall immediately provide the independent medical review organization with all necessary information and documents related to the case submitted by the enrollee, the enrollee's physician, and the health care service plan. The organization shall conduct the review in accordance with Section 1399.83 and any regulations or orders of the commissioner adopted pursuant thereto.

1399.82. (a) By January 1, 2000, the commissioner shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of any health care

service plans doing business in this state. The commissioner may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall meet in order to qualify for participation in the Independent Medical Review System.

(b) (1) The independent medical review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent entity shall not have any material professional, familial, or financial affiliation, as determined by the commissioner, with any of the following:

(A) The plan.

(B) Any officer, director, or employee of the plan.

(C) A physician, the physician's medical group, or the independent practice association either denying or proposing the health care service in dispute.

(D) The institution at which either the proposed health care service, or the alternative service, if any, recommended by the plan, would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the enrollee whose treatment is under review, or the alternative therapy, if any, recommended by the plan.

(c) The commissioner shall, by July 1, 1999, contract with a private, nonprofit accrediting organization to accredit the independent medical review entities described in subdivision (a). The accrediting organization may grant and revoke accreditation, and shall develop, apply, and enforce accreditation standards that ensure the independence of the independent review entity, the confidentiality of the medical records, and the qualifications and independence of the health care professionals providing the analyses and recommendations requested of them. The accrediting organization shall demonstrate the ability to objectively evaluate the performance of independent medical review organizations and shall demonstrate that it has no conflict of interest, including any material professional,

familial, or financial affiliation, as provided in subdivision (b), with any independent medical review organization or plan, in accrediting entities for the purpose of reviewing medical treatment and treatment recommendation decisions made by health care service plans.

(d) In order to receive accreditation for the purposes of this section, an independent medical review entity shall meet all of the following requirements:

(1) An independent medical review entity shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a health plan, or a trade association of health plans. A board member, director, officer, or employee of the independent medical review entity shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health plans or a trade association of health plans shall not serve as a board member, director, officer, or employee of an independent medical review entity.

(2) The independent medical review entity shall submit to the accrediting organization and to the department the following information upon initial application for accreditation and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent medical review entity controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review entity, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service

plan, disability insurer, managed care organization, provider group, or board or committee of a plan, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent medical review entity receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any health care service plan or provider group for which the entity provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review entity uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise in which the medical professionals are credentialed to review.

(H) A description of how the independent medical review entity ensures compliance with the conflict-of-interest provisions of this section.

(3) The independent medical review entity shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts-of-interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review entities to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) The medical professional shall hold a nonrestricted license in the State of California, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. For good cause shown, such as the unavailability of licensed qualified medical professionals in California or the availability of uniquely qualified clinics outside of California, the medical review entity may utilize a medical professional who holds a nonrestricted license in any state of the United States, provided that the out-of-state medical professional is knowledgeable about the treatment standards in California and applies those standards.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review entity, shall have any material

professional, material familial, or material financial affiliation with any of the following:

(A) The plan or a provider group of the plan, except that an academic medical center under contract to the plan to provide services to enrollees may qualify as an independent medical review entity provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the plan.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the enrollee whose condition is under review.

(F) The enrollee or the enrollee's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent entity. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(C) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of an entity or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the plan to the independent entity for the services required by this section, nor does "material financial affiliation" include an expert's

participation as a contracting plan provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The independent review process established by this section shall be required on and after January 1, 2000.

(f) The accrediting organization shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the commissioner, filed with it by an independent medical review organization seeking accreditation under this article. The accrediting organization may charge a nominal fee to the interested person for photocopying the requested information.

1399.83. (a) Upon receipt from the department of information and documents related to a case pursuant to subdivision (c) of Section 1399.81, the medical professional or professionals selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, consulting physician reports, as well as any other information submitted to the organization by the department or by any of the parties to the dispute. Following its review, the reviewer or reviewers shall determine whether the proposed treatment was medically necessary or medically appropriate based on scientific and medical evidence regarding the efficacy of the proposed or rendered treatment, or on applicable, generally accepted practice guidelines.

(b) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review from the department, or within less time as prescribed by the commissioner. If a treatment has not been provided and the enrollee's physician determines that the treatment would be significantly less effective if not promptly initiated, the analyses and determinations of the medical professionals shall be rendered within four days of the request for the expedited review. At the request of the

medical professionals reviewing the decision to deny treatment on the basis of medical necessity, the deadline shall be extended by up to three days for any delay in receiving the application and supporting and opposing documents and papers.

(c) The medical professionals' analyses and determinations shall state whether the treatment is medically necessary or medically appropriate. Medical professionals shall cite the enrollee's medical condition, the relevant documents, and the relevant medical and scientific evidence to support the determination.

(d) The independent medical review entity shall provide the commissioner, the plan, the enrollee, and the enrollee's physician with the analyses and determinations of the medical professionals reviewing the decision, a description of the qualifications of the medical professionals, and the names of the reviewers. The commissioner shall adopt the determination of the independent medical review organization.

(e) The determination of the medical professionals reviewing the plan's decision to deny treatment on the basis of medical necessity shall be binding on the plan. If more than one medical professional reviews the decision, the recommendation of the majority shall prevail. If the medical professionals reviewing the decision to deny treatment are evenly split as to whether treatment should be provided, the decision shall be in favor of providing the treatment.

(f) (1) Subject to the provisions of the Evidence Code, the opinion of the medical professional reviewer on whether the rendered or proposed treatment was medically necessary or medically appropriate may be offered for admissibility solely on that issue by a party to the medical review who calls the medical professional as his or her expert witness in any subsequent administrative or civil proceeding. Any opinion evidence of the medical professional reviewer that is admitted shall be considered only as the testimony of the party's expert witness, and not as the testimony of the medical professional conducting the medical review. Any opinion

evidence of the medical professional reviewer that is admitted shall be accorded the same weight as other expert opinion evidence and shall be subject to the same rules, including cross-examination.

(2) Any opinion of medical necessity or medical appropriateness based in whole or in part on whether the proposed or rendered treatment is a covered treatment under the terms and conditions of the health care service plan shall be inadmissible.

(g) After removing the names of the parties, including, but not limited to, the enrollee, all medical providers, the plan and any of its employees or contractors, commissioner decisions adopting a determination of an independent medical review organization shall be made available by the department to the public upon request, at the department's cost.

1399.84. (a) Upon receiving the independent medical review entity's decision issued pursuant to Section 1399.83 that a proposed or rendered medical treatment was medically necessary or medically appropriate, the plan shall promptly implement the decision.

(b) In any case where an enrollee secured health care services outside of the plan network, which services are later found by the independent medical review organization to have been medically necessary or medically appropriate, the commissioner shall require the plan to reimburse the enrollee for any reasonable costs associated with those services when the commissioner finds that the enrollee's decision to secure the services outside of the plan network was reasonable under the circumstances and the treatment or therapies were a covered benefit under the plan's terms and conditions of coverage.

(c) In addition to requiring plan compliance regarding subdivisions (a) and (b), the commissioner shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where harm to an enrollee has already

occurred because of the decision of a plan to deny, significantly delay, terminate, or otherwise limit covered health care services that an independent medical review determines to be medically necessary or medically appropriate, the commissioner shall impose penalties.

(d) Pursuant to Section 1368.04, the commissioner shall periodically evaluate independent medical review cases to determine if any audit, investigative, or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a denial, significant delay, termination, or other limits on medically necessary or medically appropriate health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.

(e) The commissioner shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(f) Aside from the application fee of fifty dollars ($50), the costs of an independent medical review shall be borne by the plan pursuant to a schedule of fees established by the commissioner.

SEC. 7. Article 2.55 (commencing with Section 10145.80) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 2.55. Appeals Seeking Independent Review

10145.80. (a) Commencing January 1, 2000, there is established in the department the Independent Review System.

(b) (1) Every disability insurance contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall provide an insured with the opportunity to seek an independent review whenever services have been denied, significantly delayed, terminated, or otherwise limited by the insurer if the

insurer's decision was based, in whole or in part, on a finding that the proposed services are not medically necessary or medically appropriate. For purposes of this section, "insured" shall include a designee and an insured's provider with the consent of the insured or the designee.

(2) The independent review process authorized by this article is in addition to any other procedures or remedies that may be available. The insured's election to either pursue or not pursue, exhaust, or engage in the procedures described in this article does not preclude the use of any other remedy provided by law and shall not be relevant in any subsequent civil or administrative proceeding.

(c) No later than January 1, 2000, every disability insurer regulated by the department shall prominently display in every insurer contract, on insured and subscriber evidence of coverage forms, on the grievance forms, and on all written notices to insureds required under the grievance process of the insurer, including any written communications to an insured that offer the insured the opportunity to participate in the grievance process of the insurer, and on all written responses to grievances, information concerning the right of an insured, as provided in paragraphs (1) and (2) of subdivision (b), to request an independent review in cases where the insured believes that services have been improperly denied, significantly delayed, terminated, or otherwise limited by the insurer, or by one of its contracting providers.

(d) An insured may apply to the department for an independent review when all of the following conditions are met:

(1) The insured's physician has recommended a treatment as medically necessary or medically appropriate, or the insured has received a treatment that the provider determined was medically necessary or medically appropriate for the insured's medical condition. For purposes of this article, the insured's physician may be an out-of-insurer physician. However,

the insurer shall have no liability for payment of services provided by an out-of-insurer physician except as provided in subdivision (b) of Section 10145.84.

(2) The proposed or rendered treatment has been denied, significantly delayed, terminated, or otherwise limited by the insurer, or by one of its contracting providers based, in whole or in part, on the basis that the treatment is not medically necessary or medically appropriate.

(3) The insured has filed a grievance with the insurer or its contracting provider, and the denial was upheld. However, the insured shall not be required to participate in the insurer's internal grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the insurer's internal grievance process for more than five business days.

(e) An insured may apply to the department for an independent review of the insurer's decision within 60 days of any of the qualifying periods or events under subdivision (d), in a manner determined by the commissioner. The commissioner may extend the application deadline beyond 60 days if the circumstances of a case warrant the extension.

(f) The insured shall pay to the department an application processing fee of fifty dollars ($50), which shall be refunded if the insured prevails in the review. The commissioner may reduce or waive the fee in cases of financial hardship. The remaining costs of the review shall be borne by the insurer as provided in Section 10145.84.

(g) As part of the application for an independent review, the insured shall provide the department with all of the following:

(1) A brief description of the insured's medical condition for which services were denied, significantly delayed, terminated, or otherwise limited.

(2) A copy of all information provided by the insurer or any of its contractors concerning its decision regarding those services.

(3) Any materials the insured submitted to the insurer in support of the grievance, and any additional material that the insured believes is relevant.

(4) A written consent to obtain any necessary medical records from the insurer, any of its contractors, and any other out-of-network physician the insured may have consulted on the matter.

(h) Upon notice from the department that the disability insurer's insured has applied for an independent review, the insurer shall provide to the department a copy of all of the following documents within five business days of the insurer's receipt of department's notice of a request by an insured for an independent review:

(A) All medical records relevant to the insured's medical condition for which the treatment has been provided or recommended, provided the documents are in the insurer's possession. Any medical records provided to the insurer after the initial documents are provided to the department shall be forwarded by the insurer to the department within five business days. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(B) A copy of any relevant documents used by the insurer in determining whether the treatment should be provided, and any statement by the insurer explaining the reasons for the insurer's decision not to provide the treatment on the basis of medical necessity or medical appropriateness. The insurer shall provide, upon request, a copy of documents required by this subparagraph, except for any legally privileged information, to the insured and the insured's physician. The department and the independent review entity shall maintain the confidentiality of any proprietary information of the insurer.

(C) Any information that was submitted to the insurer or to the insurer's contracting provider by the insured or the insured's physician in support of the insured's request for the treatment. The confidentiality of any medical

record information shall be maintained pursuant to applicable state and federal laws.

(i) Each independent reviewer shall base his or her determination on whether the proposed or rendered treatment is medically necessary or medically appropriate on scientific and medical evidence regarding the efficacy of the proposed or rendered treatment, or on applicable, generally accepted practice guidelines. A reviewer's determination shall not consider the coverage terms and conditions of the disability insurance contract.

10145.81. (a) Upon receipt of an insured's request for an independent review, the commissioner shall assign the request to an independent review organization as described in Section 10145.82 when all of the following conditions are satisfied:

(1) The insured has provided an executed release to obtain necessary medical records.

(2) The insured has submitted payment for the application fee, unless the fee is reduced or waived.

(3) The commissioner finds that the insurer's decision to deny, significantly delay, terminate, or otherwise limit treatment was based, in whole or in part, upon a determination that the proposed services are not medically necessary or medically appropriate.

(4) The insured has followed the insurer's grievance process pursuant to subdivision (d) of Section 10145.80.

(b) The department shall immediately notify the insured in writing as to whether the request for an independent review has been approved and, if not approved, the reasons therefor.

(c) If the request for review is approved, the department shall immediately provide the independent review organization with all necessary information and documents related to the case submitted by the insured, the insured's physician, and the disability insurer. The organization shall conduct the review in accordance with Section 10145.83 and any regulations or orders of the commissioner adopted pursuant thereto.

10145.82. (a) By January 1, 2000, the commissioner shall contract with one or more independent review

organizations in the state to conduct reviews for purposes of this article. The independent review organizations shall be independent of any disability insurer doing business in this state. The commissioner may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall meet in order to qualify for participation in the Independent Review System.

(b) (1) The independent review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent entity shall not have any material professional, familial, or financial affiliation, as determined by the commissioner, with any of the following:

(A) The insurer.

(B) Any officer, director, or employee of the insurer.

(C) A physician, the physician's medical group, or the independent practice association either denying or proposing the health care service in dispute.

(D) The institution at which either the proposed health care service, or the alternative service, if any, recommended by the insurer, would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the insured whose treatment is under review, or the alternative therapy, if any, recommended by the insurer.

(c) The commissioner shall, by July 1, 1999, contract with a private, nonprofit accrediting organization to accredit the independent review entities described in subdivision (a). The accrediting organization may grant and revoke accreditation, and shall develop, apply, and enforce accreditation standards that ensure the independence of the independent review entity, the confidentiality of the medical records, and the qualifications and independence of the health care professionals providing the analyses and recommendations requested of them. The accrediting organization shall demonstrate the ability to objectively evaluate the performance of independent review organizations and shall demonstrate that it has no conflict

of interest, including any material professional, familial, or financial affiliation, as provided in subdivision (b), with any independent review organization or insurer, in accrediting entities for the purpose of reviewing medical treatment and treatment recommendation decisions made by disability insurers.

(d) In order to receive accreditation for the purposes of this section, an independent review entity shall meet all of the following requirements:

(1) An independent review entity shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a health or disability insurer, or a trade association of health or disability insurers. A board member, director, officer, or employee of the independent review entity shall not serve as a board member, director or employee of a disability insurer. A board member, director, or officer of a disability or health insurer or a trade association of disability or health insurers shall not serve as a board member, director, officer, or employee of an independent review entity.

(2) The independent review entity shall submit to the accrediting organization and to the department the following information upon initial application for accreditation and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent review entity controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent review entity, as well as a statement regarding any past or present relationships the directors, officers, and

executives may have with any disability health insurer, disability insurer, managed care organization, provider group, or board or committee of an insurer, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent review entity receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any disability insurer or provider group for which the entity provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent review entity uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise in which the medical professionals are credentialed to review.

(H) A description of how the independent review entity ensures compliance with the conflict-of-interest provisions of this section.

(3) The independent review entity shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical

conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent review entities to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the insured's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) The medical professional shall hold a nonrestricted license in the State of California, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. For good cause shown, such as the unavailability of licensed qualified medical professionals in California or the availability of uniquely qualified clinics outside of California, the medical review entity may utilize a medical professional who holds a nonrestricted license in any state of the United States, provided that the out-of-state medical professional is knowledgeable about the treatment standards in California and applies those standards.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent review entity, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The insurer or a provider group of the insurer, except that an academic medical center under contract to the insurer to provide services to insureds may qualify as an independent review entity provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the insurer.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the insured whose condition is under review.

(F) The insured or the insured's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent entity. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(C) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of an entity or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the insurer to the

independent entity for the services required by this section, nor does "material financial affiliation" include an expert's participation as a contracting insurer provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The independent review process established by this section shall be required on and after January 1, 2000.

(f) The accrediting organization shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the commissioner, filed with it by an independent review organization seeking accreditation under this article. The accrediting organization may charge a nominal fee to the interested person for photocopying the requested information.

10145.83. (a) Upon receipt from the department of information and documents related to a case pursuant to subdivision (c) of Section 10145.81, the medical professional or professionals selected to conduct the review by the independent review organization shall promptly review all pertinent medical records of the insured, consulting physician reports, as well as any other information submitted to the organization by the department or by any of the parties to the dispute. Following its review, the reviewer or reviewers shall determine whether the proposed treatment was medically necessary or medically appropriate based on scientific and medical evidence regarding the efficacy of the proposed or rendered treatment, or on applicable, generally accepted practice guidelines.

(b) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review from the department, or within less time as prescribed by the commissioner. If a treatment has not been provided and the insured's physician determines that the treatment would be significantly less effective if not promptly initiated, the analyses and determinations of the medical

professionals shall be rendered within four days of the request for the expedited review. At the request of the medical professionals reviewing the decision to deny treatment on the basis of medical necessity, the deadline shall be extended by up to three days for any delay in receiving the application and supporting and opposing documents and papers.

(c) The medical professionals' analyses and determinations shall state whether the treatment is medically necessary or medically appropriate. Medical professionals shall cite the insured's medical condition, the relevant documents, and the relevant medical and scientific evidence to support the determination.

(d) The independent review entity shall provide the commissioner, the insurer, the insured, and the insured's physician with the analyses and determinations of the medical professionals reviewing the decision, a description of the qualifications of the medical professionals, and the names of the reviewers. The commissioner shall adopt the determination of the independent review organization.

(e) The determination of the medical professionals reviewing the insurer's decision to deny treatment on the basis of medical necessity shall be binding on the insurer. If more than one medical professional reviews the decision, the recommendation of the majority shall prevail. If the medical professionals reviewing the decision to deny treatment are evenly split as to whether treatment should be provided, the decision shall be in favor of providing the treatment.

(f) (1) Subject to the provisions of the Evidence Code, the opinion of the medical professional reviewer on whether the rendered or proposed treatment was medically necessary or medically appropriate may be offered for admissibility solely on that issue by a party to the medical review who calls the medical professional as his or her expert witness in any subsequent administrative or civil proceeding. Any opinion evidence of the medical professional reviewer that is admitted shall be considered only as the testimony of the party's expert

witness, and not as the testimony of the medical professional conducting the medical review. Any opinion evidence of the medical professional reviewer that is admitted shall be accorded the same weight as other expert opinion evidence and shall be subject to the same rules, including cross-examination.

(2) Any opinion of medical necessity or medical appropriateness based in whole or in part on whether the proposed or rendered treatment is a covered treatment under the terms and conditions of the disability insurance contract shall be inadmissible.

(g) After removing the names of the parties, including, but not limited to, the insured, all medical providers, the insurer, and any of its employees or contractors, commissioner decisions adopting a determination of an independent review organization shall be made available by the department to the public upon request, at the department's cost.

10145.84. (a) Upon receiving the independent review entity's decision issued pursuant to Section 10145.83 that a proposed or rendered medical treatment was medically necessary or medically appropriate, the insurer shall promptly implement the decision.

(b) In any case where an insured secured services outside of the insurer network, which services are later found by the independent review organization to have been medically necessary or medically appropriate, the commissioner shall require the insurer to reimburse the insured for any reasonable costs associated with those services when the commissioner finds that the insured's decision to secure the services outside of the insurer network was reasonable under the circumstances and the treatment or therapies were a covered benefit under the insurer's terms and conditions of coverage.

(c) In addition to requiring insurer compliance regarding subdivisions (a) and (b), the commissioner shall review individual cases submitted for independent review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where harm to an insured has already occurred because

of the decision of a insurer to deny, significantly delay, terminate, or otherwise limit covered services that an independent review determines to be medically necessary or medically appropriate, the commissioner shall impose penalties.

(d) The commissioner shall periodically evaluate independent review cases to determine if any audit, investigative, or enforcement actions should be undertaken by the department, particularly if a insurer repeatedly fails to act promptly and reasonably to resolve grievances associated with a denial, significant delay, termination, or other limits on medically necessary or medically appropriate services when the obligation of the insurer to provide those services to insureds or subscribers is reasonably clear.

(e) The commissioner shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(f) Aside from the application fee of fifty dollars ($50), the costs of an independent review shall be borne by the insurer pursuant to a schedule of fees established by the commissioner.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 9. This act shall not become operative unless Senate Bill 1504 and Senate Bill 1653 of the 1997-1998 Regular Session are also enacted and become operative.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly, May 22, 1998 (JR 11)

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